

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN1302</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/06/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAUREL MANOR HEALTH CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>902 BUCHANAN RD NEW TAZEVELL, TN 37825</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments  This Rule is not met as evidenced by: Complaint investigation #29025 was completed on Janaury 6, 2012, at Laurel Manor Healthcare. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 001		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE